

## THE SOCIAL ASPECT OF THE VENEREAL DISEASES—I

### THE WORK OF THE ALMONER \*

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The social aspect of the venereal diseases has always seemed to me to present three main problems.

- (1) That of getting the infected person under treatment ;
- (2) that of keeping the person under treatment until cure has been obtained ;
- (3) that of preventing, so far as possible, a new infection.

I should like to make it clear from the outset of this discussion that I am not an advocate of compulsory notification and treatment, because I do not believe that such a system could do more than touch the fringe of these problems. It would bring under treatment those persons who submitted themselves for examination and those who were "found out", leaving untouched the bulk of those who feared to seek treatment or who sought it in undesirable quarters. So far as the second problem is concerned, not even its advocates go further than proposing enforced treatment for persons in an infectious condition. This leaves untouched that vast amount of latent disease to manifest itself in the birth of diseased children and in many other forms in our hospitals and mental homes. As to the third of the problems, I do not think it would be of the slightest help, since fear of consequences is not a constructive deterrent.

Viewing the problems as a whole, I submit with all deference that a large part of their solution lies in good social work such as the "following up" of contacts, constructive social work within the clinics and after-care. The first of these three aspects will be dealt with by Miss Wailes and Miss Johns, so, beyond expressing my full support of the work which they and their colleagues are carrying out, I will leave it untouched and pass to the next two points. I know that I am on controversial ground and that among my listeners I have some opponents and—I hope—some supporters. I feel sure, however, that you will give me a fair hearing. I should like to direct my comments towards two main points: the work that can be accomplished and the status of the worker.

#### **Social problems in the clinic**

You are all familiar with many of the social problems which arise in the clinic. How are patients to be kept under regular treatment and observation when their private lives present such a variety of difficulties? There is the destitute girl with no home or money or friends; there is the "single" expectant mother; to them is added today, alas, the young wife whose coming baby is not fathered by her husband. There is the busy housewife whose family cares and domestic duties do not permit of treatment, because many hours of each day must be spent in the queues at the shops; there is the factory worker whose off-duty hours do not fit in with clinic times. There are family entanglements and such a lot of sorrow and misery which could be avoided or overcome if only someone had the time to listen and be available at times of stress. Then there is the problem of the default rate. This responds satisfactorily to good home-visiting by someone with sufficient knowledge to enable her to solve the social problems which the visit frequently reveals. A good visitor often traces a patient whose letters have been returned through the "Dead Letter" office and, by her personal knowledge of the patients and their home conditions, cajoles or bullies them into re-attendance.

One of our greatest problems today, as I think you will agree, lies among our young people of the age-group between school leaving and National Service ages. Shielded as they are by their elders from the brunt of the work and anxieties of the war, it appears to many of them to be the time for gaiety and easy money. Freed

\*An address to the Medical Society for the Study of Venereal Diseases, 25th November 1944.

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from the discipline of the normal family circle, since, in all too many homes, the father is in the Forces and the mother too preoccupied or too sorrowful to restrain or notice her young, they change almost overnight from children to adults. Both boys and girls need sympathetic and understanding help if they are to be prevented from ruining the happiness and fulfilment of normal manhood and womanhood. They are not "bad", these infected and pregnant fifteen- and sixteen-year-olds; they are as much the victims of the war, in their own way, as are the wounded and the air-raid casualties. To cure their disease and deliver their children, if we do nothing else, is merely to shelve our responsibilities. After five years of war the young married women need our help too, for the causes that bring them to our venereal diseases clinics are not removed by the use of drugs alone.

The venereal diseases clinic has always presented a unique opportunity for constructive help, for to its doors come the blind, the lame and the halt of all walks in life. Today that opportunity is greatly magnified and what are we doing about it? By "we" I imply the working-team which, in my opinion, can give the maximum help to the patient: the venereologist, the nursing staff and the almoner. For this brings me to the second point: the worker who can best provide this social link in the clinic and in after-care.

### **The almoner in the venereal diseases clinic**

I find that among venereologists there are two sections of opinion which are antagonistic to the use of an almoner. Some of them have never given her a trial and others have made an unwise selection. Among almoners, as among doctors and in every other walk of life, there are differing characters and temperaments and differing ideals. More than anywhere else I am sure it is essential for the director of the venereal diseases clinic to choose his almoner and then to give her a fair chance to prove her worth. The fact that in a given instance they do not share the same ideals or fit each other temperamentally seems to provide inadequate grounds for condemning the whole of the almoner service. It simply means that the director has not chosen wisely or has not insisted on making his own choice.

I believe that the almoner should be qualified and should hold the certificate of the Institute of Hospital Almoners. This is not merely because I happen to do so, but because I am convinced that it is essential for such a woman to be properly trained in the handling of people and in the social aspect of disease. Apart from this, I feel it to be essential that she should have a professional status, so that she can take her proper place and share in the work, making the third partner in the team of doctor and nurse. Her work forms the complement to theirs, giving them the picture of the social background and making it possible for the patient to benefit fully by the treatment offered. If patients are to gain what they should from its services, they need to be met in the clinic by a completely normal atmosphere. An unqualified woman, however conscientious and anxious to help, can well do untold harm through misdirected zeal; as time elapses and her lack of qualifications prevent her advance, her attitude to life will, of necessity, become narrower if not disappointed. The time is then reached when she defeats her own ends and the patient is left without help.

*The nurse-almoner?* There are some medical officers who advocate the use of a "nurse-almoner", on the grounds that only a qualified nurse is of any use in dealing with venereal diseases patients. May I submit that to overcome the social obstacles in the way of a patient's return to self respect and her readjustment as a member of society calls for a wide and comprehensive knowledge of social conditions and the means to handle them. This work demands an up-to-date and intimate knowledge of social legislation and of the innumerable state and voluntary agencies which can be utilized to the patient's advantage. Disease needs to be studied continually from the social aspect, with its effect, and that of treatment, on family relationships or employment and the resultant psychological reactions. Since nursing is a totally different profession, which demands exact and scientific knowledge in fighting disease and winning the patient back to health, it is beyond the powers of the average woman to be properly trained and reliably up to date in

both professions. If she is to be properly qualified for both sides of the work, seven years would have to be spent in training with heavy fees for a very small economic return ; at the end of it she would either be useless through the attempt to keep up to date in both capacities or, as the years advance, would become a better almoner and a useless nurse or else a better nurse and a useless almoner. How can the patient gain through such confusion of function ? On the other hand, the trained almoner, working in close cooperation with the trained nurse and the medical staff, can give the patient the maximum amount of help.

*Health visitor or almoner ?* Other medical officers advocate the use of the health visitor in place of the almoner. The health visitor is concerned with the home from the aspect of public health. The expectant mother and the "under fives" are especially her province but, even in her work with them, she is neither trained in the understanding of nor concerned with social conditions or with family relationships and their psychological reactions. Many of the patients who most need help, such as the destitute girl, the young boy and the fifteen-year-old girl on the street, are altogether beyond her reach. Social work in the clinic must include rehabilitation and after-care, and the prevention of default in attendance at the clinic is only one aspect of it.

*Almoner and contact tracer.* Others again are tempted to regard the almoner as a contact tracer. I have every sympathy with this very essential aspect of the work, but would like to urge that the almoner's place is in her clinic. If she is out tracing those who have not yet sought her help, she is not there when she is needed urgently by those who have. Visiting among patients is "following-up" "within the family", as it were ; it is calling where home conditions and family background are known and where, in spite of the patients' reluctance to come to the clinic, they know at heart that the caller cares for their welfare or that of their children. The almoner's duty is to keep her patient under treatment and by personal knowledge, often extending over several years, to prevent, so far as is possible, a further break-down. Everything rests upon the foundation of trust which she is able to establish between herself and her patient.

Contact tracing needs wide extension and it should grow like a snowball. The almoner, to be of any use, needs to be on the premises while the medical officer is in session ; she requires time for "follow-up" visits, letter writing and necessary office routine ; she needs, too, to offer opportunity for quiet talk to those of the patients, both men and women, who require her counsel and practical help. Once again, I repeat that the work of the almoner and of the contact tracer are two whole-time tasks.

May I, in conclusion, quote to you from the leading article in the *Lancet* of 1st July 1944 ?

"Contact tracing is no part of the duty of the clinic almoner except in so far as she is in a position herself to persuade the patient to take some action to this end. Her role, *inter alia*, is to help the patient through the difficulties inseparable from what is at best a trying and tedious time, to assist in rehabilitation and to do all she can to prevent default from treatment. Compulsory powers might aid her in dealing with a small refractory minority, but her success or failure otherwise will continue to depend, as it does now, on her personality and her capacity for friendship."

### **Appointment of almoners**

You may remember that at the meeting in February 1943 of the Central Council of Health Education, I said that there were only 6 almoners working in the venereal diseases clinics, of whom only one was to be found outside London. Now, in November 1944, there are 29 clinics which have almoners, of which 18 are outside London. Is this number to be further increased among the other 165 clinics and what, in the meantime, is happening to the young folk who need an almoner's care ?